COMPETITIVE TENDERING: A MOVE FOR EFFICIENCY OR AN ATTACK ON THE NHS?

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Over recent years the present Government has pursued an extensive programme of privatisation. The purpose of this paper is to examine the exercise of competitive tendering, which the government has imposed with great persistence on the National Health Service. The paper aims to assess, by examining the impact of competitive tendering on job conditions, standards of service and industrial relations, how the government rhetoric about 'efficiency' relates to deeper political objectives.

What is Competitive Tendering?

The process of competitive tendering involves testing the cost effectiveness of a service by putting it to tender so that the in-house service will be subject to competition from the private sector. This is not strictly the same as privatisation but clearly has the potential to produce the same effect.

While the Government have been promoting competitive tendering in the NHS since as early as 1980, it was only in 1983 with the issue of DHSS circular HC(83)18[1] that the prerogative of choice was removed from Health Authorities. The circular not only stated a preference for the practice of competitive tendering but also a clear preference for the use of private contractors. It is important to note also that in the policy guidelines for the appraisal of tenders, the circular clearly places price as the most important appraisal criterion, not service quality.

English Experience

Despite Government claims that competitive tendering introduces competition which results in improved efficiency and financial savings, evidence from England paints a quite different picture. In the first instance, competition was largely eliminated in the first round of tendering by the virtual duopoly of the two leading conglomerates BET and the Hawley Group (who between them held 60% of the domestic market share at March 1988[2]).

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Secondly, claims of improved efficiency are much weakened by widespread evidence of disastrous service standards[3]. Domberger et al[4] carried out a study to assess the cost implications of competitive tendering and to see if the process resulted in the same benefits that had been highlighted by previous research into competitive tendering of refuse collection[5]. Although they found that similar savings were possible, there was a marked difference in the quality of service provided. Contractors' failure was "far more widespread than was encountered in our earlier study of refuse collection"[6]. The Joint NHS Privatisation Research Unit (JNPRU)[7] found contract failure to be particularly high among private contractors (at May 1987 the Market leaders BET and Hawley had failure rates of 22% and 25% respectively.) The Unit feels that this poor service is largely responsible for many English health authorities restoring contracts to the in-house team in the second round of tendering.

Thirdly, the extent of financial savings claimed, (Domberger et al estimated 20% "achievable cost reductions"[8] and the National Audit Office reported 22% savings on private contracts and 21% on in-house contracts[9]) is somewhat dubious when considered alongside extra costs incurred by competitive tendering, which are not included when calculating savings. (The nature of such costs will be discussed below). Even government publications give evidence that savings are being made at the expense of the already low-paid staff: "savings have arisen mainly from ... less favourable conditions of employment, greater use of part time staff, changes in working practices and increased productivity"[10].

COMPETITIVE TENDERING IN SCOTLAND

This section outlines the stages of the competitive tendering exercise in Scotland, looking at the different responses of Scottish health boards, more recent developments designed to alter that response, the reaction of the trades union movement, and the present situation.

Round 1: The Early Circulars

The Scottish Office circular 1983(GEN)13[1], coinciding with the original DHHS HC(83)13, received considerably less attention than its equivalent south of the border, the Boards being generally against any form of privatisation in the NHS. In June 1984 the Scottish Home and Health Department (SHHD) issued another circular, 1984(GEN)14, "to stimulate further progress towards seeking tenders for services". Despite receiving reports of progress being made in efficiency programmes, the Minister was not satisfied. He insisted that "the achievement of savings depends on seeking tenders for particular services". The tone of this circular was considerably more insistent that the last, stating that by the end of December 1984 all boards (except the Islands) were to have put to tender the domestic and catering services for their own head offices and for at least two hospitals

per board.

There followed considerable debate among health boards about whether the exact status of this circular was that of a mandatory directive or not. The Scottish Health Minister, was evasive on this point, stating simply that as appointees of the Secretary of State, health boards were answerable to him and to Parliament. Legal advice was sought by unions who were informed that the circulars put no statutory duty on health boards to comply[12].

At this point the health boards became divided in their approach to the department directives and there followed a period of meetings at the various boards to decide on their policy. During this period individual unions sought to demonstrate their opposition to the proposal and a series of strikes and demonstrations spread throughout the country. It would be impractical to list all the action taken as much of it involved lightning strikes around the country, but major strikes and demonstrations took place in Fife, Tayside, Lothian and Lanarkshire areas. The largest of these was a demonstration in Fife by several thousand ancillary workers coming from Fife, Tayside, Lothians, the West Coast, Glasgow and as far afield as the Highlands. This demonstration, consisting of a march and rally, coincided with the Boards decision as to their tendering policy and was intended "to focus and enlist public support against government attempt to sell off the health service"[13]. The sizes of subsequent demonstrations ranged from a few hundred to about 3,000.

While this action did indicate the strength of opposition, and was undoubtedly a major influence on the decisions of some boards, notably Fife and Lothian, it was not successful in all cases. Table 1 summarises the position of the boards once all decisions had been made. At this point Scottish health boards seemed to be split down the middle. However, even those that did accept tendering proposals did so in the spirit rather than the letter of the circulars, concentrating mostly on non-hospital services.

Meanwhile it was reported that the Health Minister had written to the five rebel health boards making it clear that he would "continue to insist on competitive tendering being the only firm test of the savings available". He called on these boards to submit a report by April 1985 on savings planned and secured, "not ruling out the possibility of using his powers to direct them if co-operation is not forthcoming. He could ultimately find board members to be in default and dismiss them"[14]. This clearly indicates the government's determination to implement competitive tendering, regardless of the efficiency agreements that boards had implemented in its place.

Table 1: Position of Scottish Health Boards re Tendering Proposals.

HEALTH BOARD	ACCEPTED	REJECTED	COMMENT
Argyll and Clyde		X	
Ayrshire	X		
Borders	X		
Dumfries & Galloway	X		In-house service only feasible tender
Fife		X	This, the first decision, received largest lobby. Unions saw it as victory. J. Balfour, board chairman denied they had succumbed to union pressure.
Forth Valley	X		But only for non-hospital services.
Grampian		X	Concrete agreement drawn up with unions to achieve savings. The agreement intended to operate until 1991, including a moratorium on privatisation.
Greater Glasgow		X	Board Chairman: "the board's responsibility is to the patients and with that in mind it was in the interest of the patients to put off any question of privatisation.
Highlands		X	
Islands Health Boards	Not Applicable: excluded from government proposal.		
Lanarkshire	X		Agreed to take on a pilot exercise at 3 hospitals.
Lothian		X	
Tayside	X		

Other Developments

Whilst this open battle between the unions, the health boards and the Health Minister was raging over the decision whether or not to follow the government proposals the following developments were taking place in the Scottish Office which were to pave the way for the smoother implementation of competitive tendering in later stages.

(i) The Change in Health Minister

John MacKay and his successor Lord Glenarthur had become increasingly insistent that health boards should comply with SHHD circulars on competitive tendering but the current Health Minister, Michael Forsyth, was to adopt a much more determined and authoritarian approach. In the words of a Scottish Health Service Campaign report "the position is now filled by someone with a fierce ideological commitment to the free-market and an enthusiasm for Health Service privatisation which was not to be found in his predecessors".

The Scottish Trades Union Congress (STUC) claim that Forsyth's "highly co-ordinated strategy" has involved the collaboration of senior Scottish Office civil servants, health board general managers and the contracting industry "to ensure that private contracting is forced on Scottish health boards". Their claim is supported by evidence of meetings arranged by Mr Forsyth with board general managers and representatives of contracting companies which were not reported or publicised in any way. One such meeting in the Highlands established that the department letter (see below) "conveyed a direction from the Minister"[15]. The purpose of such meetings was apparently to exclude the health unions, the STUC and other opposing parties and to allow the implementation of a co-ordinated programme of contracting out.

(ii) The Morison Letter

An SHHD letter of December 1987[16] was of considerable significance in changing board policy. In comparison to previous circulars the Morison letter (so called after its signatory Hugh Morison) was far more insistent in its tone, which was that of a legal directive. For example in paragraph 6 it states "there should be no question of boards considering *whether* they propose to achieve" the programme (my emphasis). Furthermore, it refers to section 2 of the 1978 National Health Act in which boards will be bound by a "direction" made by the department. This started once again the debate about the legal status of the circulars. STUC assistant secretary Bill Speirs sought clarification from the SHHD and was told that the letter was not a direction. While Malcolm Rifkind, Secretary of State, and Michael Forsyth have both been evasive about the exact legal status of the letter, Forsyth makes his interpretation quite clear:

> "Health boards are appointed by the Secretary of State to act on his behalf ... and they are under an obligation to do so in accordance with government policies"[17]. In a parliamentary question he stated "the letter of 11 December ... sets out firm instructions by the Secretary of State on action boards are to take, and they are obliged to implement them".

The impact of the letter on board policy has been considerable and even those boards still largely opposed to competitive tendering felt that they were now forced to comply. One such board was Argyll and Clyde, which previously rejected competitive tendering in favour of making efficiency agreements with the unions. Mr J Ryan, Chairman of the board clearly indicated his opinion by stating that existing services were efficient and he could not see how privatisation could bring any substantial savings. He felt that the board had been forced into compliance with competitive tendering proposals and told protesters that if the board refused to comply, they faced the imposition of Scottish Office appointed commissioners to implement the proposals[18].

The Reaction of the Trade Union Movement

As the boards entered this second phase of competitive tendering many of them were in the position of having made efficiency agreements with the unions on the understanding that competitive tendering would not be introduced. In Grampian the board and unions had actually signed a comprehensive agreement including a moratorium on privatisation, which was to last until 1991. Therefore, as the boards began to change their minds, health workers (particularly those in Grampian who had already saved the board £2m in just one year) expressed their bitterness in one of the strongest union campaigns to have taken place in the NHS. From the beginning of the year union members were 'voting with their feet' and coming out in sporadic action around the country. Throughout January there was a series of walk-outs and lobbies as health boards came to their decisions on whether to invite private tenders. In Lothian 30 hospitals were affected as 2,000 staff staged a 24 hour stoppage, in Greater Glasgow several thousand members demonstrated at the board's offices, and in Ayrshire and Arran 1,000 workers attended a lobby and presented a petition of 16,000 signatures opposing privatisation. Many more demonstrations occurred after decisions had been taken. Action also sprang up in traditionally more moderate areas such as the Highlands.

This wave of action was initiated largely by the Joint Trade Union Committees of individual health boards but was not backed up by any organised STUC campaign, other than a propaganda campaign similar to that operated in previous stages. From February, however, the STUC claimed its support for the rolling programme of protest action. Such action was widespread around the country and was taken by NHS employees from a range of occupations. Much of the action was sporadic and poorly organised and in some hospitals workers were coming out in numbers of less than ten, the impact of which was often limited. But there was particularly well supported action in the Lothian and Greater Glasgow areas. For example on the 10th February 1988, over 1,000 workers staged a 24 hour strike affecting eight hospitals around Glasgow. On the 5th February, 385 ancillary and nursing staff from Edinburgh Royal Infirmary

walked out and were supported by the stoppage of 500 administrative and clerical staff.

While this programme of action was perhaps poorly organised the main focus of attention of the campaign, the national NHS DAY OF ACTION (February 24th) was well planned in advance and actively supported by the STUC. The Health Minister attempted to dampen support for the action, issuing statements like, "The Trade unions are organising an attack on patient care in order to oppose competitive tendering which will increase the resources available for the sick. I hope all those NHS staff who know where their interests lie will not abandon their patients to join a politically motivated campaign"[19].

Despite this, the support of health workers, sections of the wider trade union movement and of the public remained strong. On the Day of Action the numbers involved far exceeded expectations. The following are the figures reported by the *Glasgow Herald* 25/2/88:

Location	Number Attending
Glasgow George Square	25,000
Edinburgh	20,000
Aberdeen	11,000
Dundee	7,500
Inverness, Dumfries, Fife Orkney, Lochgilphead	5,000
	68,500

However, estimates of numbers attending such demonstrations are notoriously unreliable and other figures quoted range from 50,000 (*Times* 25/3/88) to 70,000 (NUPE). Furthermore, there was some opposition to the STUC campaign. A small number of members of the pressure group Public and Local Services Efficiency Campaign (PULSE) picketed the STUC offices to voice their protest against strike action.

Nevertheless, the strength of public support had been in little doubt from the beginning of the campaign. This has been backed up by the result of two separate opinion polls, the System Three poll commissioned by the STUC and a poll organised by NUPE of visitors to hospitals in the Monklands district. The table below highlights the major findings. The support illustrated by these results was also found to cross the boundries of political affiliation.

Table 2: Public opinion on NHS Questions

NB Monkland's Poll: survey of 1172 visitors to hospitals in Monkland's district on 24 February 1988.
System 3 Poll: survey of 968 respondents in 39 Scottish constituencies over the period 26th February to 6th March 1988.

QUESTION	MONKLAND'S POLL (1172 respondents)	SYSTEM 3 POLL (968 respondents)
Are you for or against the introduction of competitive tendering for hospital services? AGAINST:	–	72%
Do you believe that privatisation of hospital services will improve health care? NO:	93%	–
Do you think that health service staff, including nurses, would be justified in taking industrial action over the future of the NHS? YES:	87%	72%
In the next budget the Chancellor of the Exchequer will be able to choose between cutting income tax by 2p in the pound or putting an extra £2 billion into the NHS. Which do you think he should choose? £2bn to the NHS	99%	86%

Source: Scottish Health Service Campaign Report:
"System 3 NHS Opinion Poll Results" March 1988
Glasgow Herald 12/3/88.

Throughout this period of action the health unions made offers to call off the industrial action if Mr Forsyth would withdraw his circular instructing boards to put services out to tender. He continued to boast that he refused to be pressurised by the unions: "I want to make it clear that there is no possibility of industrial action of this nature changing the government's policy on competitive tendering for ancillary services"[20]. Partly due to the Minister's intransigence and partly from a fear of losing the support of the public, the STUC NHS privatisation sub committee entered a 'new phase' in their campaign. It was agreed that "the campaign strategy be modified to

a) protect the position of staff currently directly threatened by competitive tendering and privatisation
b) focus directly on the government and in particular on Health Minister, Michael Forsyth
c) step up pressure on those companies considering bidding for NHS contracts"[21].

What this effectively amounted to was an admission that competitive tendering was here to stay and all that remained was to try to ensure that the in-house bids were satisfactory to staff and for patient care, while at the same time being sufficiently competitive to compete with private firms. This was the dilemma now facing the unions, these two objectives hardly being compatible considering that under SHHD instructions boards are unable to specify wages and conditions as a condition of tender and that since the abolition of the Fair Wages Resolution, contractors are not bound by Whitley conditions.

The first step in the 'new phase' of the STUC campaign was to suspend all industrial action to allow meaningful negotiations with the Scottish Office. Any further action would be a matter for individual unions but would not receive official STUC backing. Many among the rank and file were disappointed at this move, seeing it as an acceptance that competitive tendering was here to stay and almost an admission of defeat.

Over the next few months there continued to be signs of this split between some of the more militant groups among the rank and file and the official union approach. The former continued to organise sporadic industrial action and this was particularly noticeable in the Lothian region where NUPE had announced that any action arising would have full union support. Having voiced such support however, the union was not prepared to organise any action itself, leaving such decisions to the members of individual hospitals. While action did arise for the first few weeks following Lothian health board's decision to privatise certain services, the 'rolling campaign' was soon to peter out.

Over the same period the official NUPE line had fallen into step with the STUC line that it was now important to concentrate on co-operation with local management in preparation of in-house tenders to make them as competitive as possible. However, this was not necessarily possible for local union branches. In Glasgow and Lothian particularly, where the unions had previously been most adamant in their non-cooperation, local management were now excluding them for tender preparation despite offers of cooperation. This proved to be disastrous for the ancillary services as it was in these areas that most private contractors were successful. From this point onwards the unions' remaining weapons were to persuade members not to accept re-employment with private contracts (and we will see later that staff shortages have been a major problem for some

companies) and to discredit the contractor's performance.

The latest move in the STUC's campaign has been to challenge health boards through the courts about the procedures being used to evaluate tenders which are seen as discriminating against NHS employees. The claim relates to the 'hidden costs' of outside contractors (see below) which are not considered in the evaluation of their tenders. Such a legal move was made in Lothian on 24 May 1989 when a petition was lodged for an interim interdict on the health board regarding the awarding of another domestic contract. This hearing however was dropped after the board announced that no decision would be made on the contract until at least June 22nd. The Union felt that they had at least achieved a delay in the process.

The Current Position in Scotland

Table 3 below outlines the outcomes of all contracts awarded by the end of May 1989. Competitive tendering is an ongoing process and there are a considerable number of contracts currently in the process of being tendered. Most of these are for domestic and catering services although there is an increasing number of 'multiple-service contracts' going to tender, which cover the whole range of hotel-type services used in hospitals and clinics. Some health boards are even considering putting a much wider range of services out to tender. In Forth Valley feasibility studies are currently underway to decide on the competitive tendering of pharmacy, laboratory, X-ray and medical records services. However, this appears to be the exception rather than the rule.

We can see from the table that most of the health boards have responded in one of two ways, either to wholeheartedly embrace the policy, showing a definite preference for contracting out, or to follow the proposals to their minimum requirements and preferring to keep services in-house. Overall 80.4% of contracts let so far have been awarded in-house which woud appear to indicate either a lack of acceptable tenders from private contractors or a reluctance in health board management to contract out. There are, however, a few important exceptions to this. These are the areas where there has been most controversy over the tendering results: Greater Glasgow, Grampian and Lothians. Greater Glasgow in particular has demonstrated its commitment to the principle of competitive tendering and indeed to the privatisation of services. Half of the contracts so far awarded in the area have gone to private companies.

In Grampian, where four contracts have been awarded, the private contractor Mediguard won two of these. The decision to award Mediguard the contracts greatly shocked the unions and some board members since three separate reports expressed grave concern about the quality of the tender. One report, from the West Midlands Regional Health Authority, states that "the Mediguard tender proposed input hours which in our opinion would not be sufficient to guarantee that the contract standard

Table 3: Outcome of Tendering to end of May 1989

Health Board	Service	Contracts In-house	Contracted Out
Argyll & Clyde	Domestic	3	
	Catering	2	
Aryshire & Arran	Domestic	3	
	Catering	2	
	Vehicle Maintenance	1	
Borders	Domestic	1	
	Catering	1	
Dumfries & Galloway	Domestic	1	
	Catering	1	
Fife	Domestic	1	1 (Initial Health Care Services)
	Catering	2	
Forth Valley	Domestic	2	
	Catering	2	
Grampian	Domestic		2 (Mediguard)
	Catering	1	
Greater Glasgow	Domestic	4	10 (IHCS, Hospital Hygiene, Dysart, Sunlight)
	Catering	8	1 (Sodexho)
	Portering		1 (IHCS)
Highlands	Domestic	1	
	Catering	1	
	Laundry		1 (Lairg Electric)
Lanarkshire	Domestic	7	
	Catering	1	
Lothian	Domestic		2 (IHCS)
	Catering	2	
	Grounds & Gardens	4	
Tayside	Domestic	31	2 (IHCS Mediguard)
	Catering		
		82	20

would be met"[22]. Concern was also expressed about the level of sickness allowance, the quality of training and the racial equality policy. However, the real controversy arose when confidential minutes were leaked showing that Mediguard had clinched the deal by offering 650 extra hours at no cost to the board. Other confidential documents indicated that in-house bids had been rejected at an early stage without the chance for re-submission. These revelations naturally aroused suspicions about unfair bias in favour of the private company. There was similar controversy in Lothian when the successful bidder, Initial Health Care Services (IHCS) had put in tenders which were just marginally lower in price and which left certain gaps in the service provision.

Why then, we might ask, should different health boards respond in such different ways? It is interesting to note that with the exception of Tayside, all those boards which are now contracting out are those which previously rejected competitive tendering altogether. This can not be entirely coincidental, but is likely to be closely connected with the NHS management reforms implemented following the Griffiths report in 1984[23]. This report attacked the existing structure of consensus management in which decisions were reached by the consensus of a number of representatives of different interests (e.g. administrator, a financial manager, a nursing officer and a doctor). To replace this system, Griffiths proposed the appointment of a General Manager at district and unit levels, who was to "accept personal responsibility for developing management plans" and to provide the "driving force" that was currently lacking.

The proposals were not well received by the unions, nor by the Social Services Select Committee investigating the report. The most important objection has been that the reforms have been found to lead to a centralisation of power into the hands of the Secretary of State through General Managers. I think that it is here that we can find the reason for the extremes in the health board policy. By their rejection of the government proposals in early 1984, these health boards became priority targets for management reform. The General Managers appointed in these areas, particularly in Glasgow, Grampian and Lothian, have proven to be faithfully committed to the policy of competitive tendering, among other government policies such as the encouragement of commercial medicine. Due to the increased centralisation of power such commitment is more easily translated into implementation.

The Impact of Competitive Tendering on Costs and Services

Scotland is now well into its first round of tendering, with many of the contracts six or seven months into their operation. So, it is possible to examine how the impact of the process so far measures up to government claims of savings and improved efficiency.

Savings

Table 4 gives the figures for savings achieved in ancillary services as a result of competitive tendering. These figures were obtained directly from individual health boards.

Table 4 Total Savings Made to Date as a Result of Competitive Tendering (As at June 1989)

Health Board	No of Contracts Awarded	Savings £	Savings %
Argyll & Clyde	5	211,822	7.8
Aryshire & Arran	5	186,000	7.2
Borders	2	107,000	7.6 (Catering Only)
Dumfries & Galloway	2	200,000	8.0
Fife	5	113,059	6.6
Forth Valley	4	900,000	24.0 (Domestic Only)
Grampian	4	597,944	14.6
Greater Glasgow	24	5,236,718	29.0 (Average)
Highlands	3	152,000	11.8
Lanarkshire	8	729,052	17.8
Lothian	8	1,300,000	20.0 (Domestic & Catering 42.0 (Grounds & Gardens)
Tayside	33	2,000,000	(Not Available)
Total Savings		12,033,995	

The total savings figure of over £12 million, while considerable, is nevertheless far short of the £16 million savings claimed by Michael Forsyth (April 1989). The most likely reason for this discrepancy is that the Scottish Home and Health Department is including in its calculations the savings achieved by a number of efficiency programmes which were already in operation when competitive tendering was implemented. For example in Dumfries and Galloway, of the £500,000 savings it was estimated that just £200,000 were directly attributable to competitive tendering. This ambiguity is most likely to occur where the contracts have been awarded in-house.

However, this is not likely to be the case where private companies have been successful, as a complete take-over makes cost comparisons more straightforward, and it is in the areas with a high level of contracting out that the greatest savings are claimed. My second and more important reservations about these claims is that, as was the case in the first round of tendering in England, there are a number of 'hidden costs' which are not taken into account when calculating savings.

(i)Tendering Process

Perhaps the most obvious costs incurred are the manhours, consultancy fees and direct costs (stationary, printing etc) involved in the preparation of timetables, drawing up of specifications, and inviting and evaluating tenders. Few of the health boards have made any attempt to calculate these costs. Those that provided figures are listed below.

Table 5: Direct Costs of Competitive Tendering Process

Health Board	Savings	Cost	Note
Ayrshire & Arran	£115,000	£51,000	Relates only to 4 contracts let in 1988
Borders	£107,400	£17,568	Staff cost only i.e. excludes external consultancy fees
Grampian	£597,944	£25,242	

A further on-going cost of the process is in the necessary monitoring of contract performance but it is virtually impossible to put a figure on this.

(ii) Severance Payments

Redundancy costs arising from a given tender are, under DHSS guidelines, to be counted as a 'below the line' cost which means they are to be recouped against savings over the period of the contract. This clearly works to the advantage of private contractors whose redundancy costs would otherwise push up the price of their tender.

Figures for relevant redundancy and early pension payments were requested by Sam Galbraith MP in a parliamentary question. The total comes to £4.8 million which is payed out of central funds in Scotland.

(iii) VAT

Under Treasury policy health boards may now reclaim VAT which has been paid as a result of contracting out any service. Therefore, the government is giving up revenue to encourage contracting out. An exact figure is very difficult to obtain as the Scottish Office does not collect the information and Customs and Excise would not reveal it. However, Bill Rankine[24] has estimated that contracts let to private companies in Scotland so far, with total value of over £10 million, would incur VAT charges of about £1.5 million which have been relinquished by the government.

(iv) Social Security Costs

Social security payments to former NHS staff who remain unemployed are a continuing 'cost' of contracting out. Rankine[25] using health board figures estimates that 2,500 NHS workers were made redundant and around 600 of these remain unemployed. Taking the period of 13 weeks from the end of 1988 (when the first private contracts began operation) and an average of £80 per week per claimant, the social security costs as at April 1989 would have come to £620,000.

(v) Obsolescence of Equipment

It has also been claimed that allowance should be made for expensive NHS cleaning equipment which is lying unused or has been sold off at rock bottom prices.

Unfortunately, it is virtually impossible to calculate these costs accurately as the necessary official information is not available. Therefore, while health board and government claims of savings can neither be proven nor disproven they must surely be thrown into considerable doubt.

Efficiency

The second major element in the government rhetoric on competitive tendering is that it will improve the efficiency of services now facing competition with the private sector. We have seen that considerable savings have already been made (the extent of which is questionable) which would suggest that the services were indeed operating more efficiently. However, in the words of Domberger et al[26] "Clearly if cost savings are achieved at the expense of lower service standards then we will have overestimated the benefits of tendering."

Competitive tendering in Scotland has now developed sufficiently for us to form some idea of whether the problems that have arisen in England are also likely to arise here. So far, none of the contracts have actually failed and indeed the problems of poor service standards do not seem as widespread in Scotland as they were in the first round of tendering in

England. The most likely reason for this is the greater proportion of successful in-house tenders in Scotland. In these cases reductions in service standards have been minimal although staff are finding that they have more work to do in less time.

Serious problems have, however, arisen with some of the private contracts. One that has attracted considerable attention is Initial Health Care's domestic contract at Edinburgh Royal Infirmary. When the company first took over the contract, they had great difficulty in recruiting sufficient staff, achieving only 50% of their requirements. These shortages seriously impaired the standards of cleaning and on one occasion IHCS had to import bus loads of staff from Middlesborough, paying them £150 per head per day, to make up the numbers. (NUPE members claim that this has been a regular practice, which Initial deny). The company continued to suffer recruitment problems despite having taken the unprecedented step of putting wages up and introducing a bonus just weeks into the contract period[27].

Hospital Hygiene have also had problems with discontented staff. After the first month of the contract at Victoria Infirmary, Glasgow, 100 domestic workers walked out as their pay was overdue and a similar dispute was narrowly avoided in their Stobhill contract by guarantees that cheques would be delivered[28].

These incidents are clear indications of the spreading discontentment among ancillary staff. While most of the contractors continue to pay the Basic Whitley rate of £2.029 per hour (though one contractor in Glasgow pays as little as £1.75 per hour) they have cut back hours to such an extent that individuals are taking home considerably less pay. This is clearly the main source of savings made.

The combination of staff shortages and the demoralisation of remaining staff is proving detrimental to service standards. The Royal College of Nursing is continually receiving reports from senior sisters that due to unsatisfactory cleaning standards nurses are having to do extra cleaning in addition to their own duties. In such cases competitive tendering does not only impair the standards of contracted-out service but also puts pressure on the resources of the primary service of medical care.

Conclusion

The experience of competitive tendering in England has shown that the exercise has achieved little in terms of 'efficiency' and 'savings'. Evidence from Scotland, while not yet as advanced, already shows that the savings made are largely at the expense of the already low paid staff and the efficiency of the service has suffered in many cases from severe staff shortages resulting from the poor pay and conditions offered.

Overall, therefore, the evidence appears to suggest that 'efficiency' is not genuinely the government's main interest in competitive tendering. So what are the government's real motives, and why is it concentrating so emphatically on the rationalisation of support services when there are other areas in the NHS where attention could be turned?

Before answering this we must consider the context in which competitive tendering has arisen. The present government is dedicated to a programme of privatisation and has been able to sell off a number of public industries with relatively little opposition. However, the NHS, the largest public sector employer, has proven to be rather different due to its immense popularity. This means that attempts to break down the NHS in its present form have had to be done by rather less obvious techniques. Competitive tendering is one such technique and there are three important ways in which it assists this overall attack on the NHS.

First, competitive tendering aims to break up the NHS into more manageable segments. By having support services put to tender, the government is trying to undermine the idea that ancillary staff are an essential part of the health care team. In the words of David Currie, a consultant neurosurgeon in Aberdeen. "Of course, the threat to the ancillary services is not really about efficiency or financial savings ... The real reason for this piece of sabotage is to prepare the ground for further dismantling of the NHS, and Mr Rifkind has placed the ancillary workers in the frontline because they are the most vulnerable section of the service"[29].

A second advantage of competitive tendering for the government is the weakening effect it will have on the health unions, previously among the strongest public sector unions. The government welcomes the introduction of private contractors who may or may not chose to recognise existing health unions and who will employ a part-time, largely female workforce, notoriously difficult to organise. This opinion is clearly supported by the right-wing pressure group PULSE (Public and Local Service Efficiency Campaign): "Instead of having one monolithic in-house organisation providing services there will be a welcome fragmentation and the natural consequence of that is decreasing unionisation. The unions may continue to have members in the firms involved but competition means that they know there are other companies available to do the job if they go on strike"[30]. This weakening in union power will leave ancillary workers increasingly vulnerable to squeezing on their already low wages.

Finally, it is the government's intention to aid the advancement of the private sector. The preference of the Scottish Office for contracts being awarded to private tenderers has never been in doubt. Minutes of the Highland Health Board meeting (18/12/87) state that boards "were

expected to concentrate on areas where the most attractive financial packages could be presented to commercial contractors"[31]. This would surely suggest that the Scottish Office gives the interests of the contractors a definite priority over the wider interests of the Health Service.

These three factors, the fragmentation of the NHS workforce, the weakening of the health unions and the furtherance of the private sector, are the underlying objectives behind the government's insistence on the implementation of competitive tendering. Though the process has clearly done little to improve efficiency as government rhetoric claimed it would, in terms of these underlying objectives it might be seen as a success. Such objectives have been achieved at the expense of the low paid ancillary workers and to the detriment of NHS users who are having to accept increasingly low standards from a service that has been stretched to the limit.

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3. It is impossible in the space provided to list the numerous complaints about service standards that have arisen around the country. The Joint NHS Privatisation Research Unit (JNPRU) publication *Contractor's Failures: The Whole Story: 1983-1987* and subsequent updated pamphlets give full details of such complaints.
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